

policies restricting Medicaid coverage of abortion make the procedure financially inaccessible for some women seeking an abortion, forcing some to carry an unwanted pregnancy to term. Women forced to carry their pregnancy to term are more likely to fall into poverty and their newborns and existing children are more likely to suffer from adverse health and well-being outcomes.

4. Low-income women and women of color are disproportionately covered by public health insurance programs. As a result, restrictions on Medicaid coverage of abortion disproportionately harms these groups and increases their socioeconomic disadvantage.

5. Finally, research confirms that Medicaid-eligible women who are ultimately able to obtain an abortion but are denied Medicaid coverage for an abortion are likely to suffer significant consequences. These include delays in accessing abortion care (which increases the costs and potential for rare complications with the procedure) as well as diminished well-being as women with few financial resources may be forced to sacrifice basic household necessities (like food and utilities) in order to raise money for the procedure.

6. Based on my close familiarity with this research and my own work with Ibis Reproductive Health, a nonprofit research organization, as well as demographic surveys of abortion seeking patients, it is my expert opinion that Pennsylvania's policy withholding Medicaid coverage for abortion except in cases

of rape, incest, or life endangerment makes it difficult, and in many instances impossible, for poor women who are otherwise eligible for state-subsidized medical care to obtain abortions.

I. Background and Qualifications

7. Since 2016, I have been an Associate with Ibis Reproductive Health (Ibis), a nonprofit organization that drives change through bold, rigorous research and principled partnerships that advance sexual and reproductive autonomy, choices, and health worldwide. The organization conducts research that focuses on increasing access to safe abortion, expanding contraceptive access and choices, and integrating HIV and comprehensive sexual and reproductive health services. In this role, I lead Ibis's research program focused on documenting the impact of the Hyde Amendment—a federal legislative provision with state counterparts that prohibits public funds from being used to cover abortions unless the life of the woman is endangered, or the pregnancy is a result of rape or incest—on low-income women and abortion providers. Under this research portfolio, I oversee initiatives that examine and describe 1) Women's experiences seeking abortion care in the absence of public insurance, 2) The consequences of out-of-pocket costs for abortion care, 3) The impact of Medicaid reimbursement on abortion care provision, and 4) Changes in abortion access prior to and following the enactment of state policies related to public coverage of abortion.

8. Prior to coming to work for Ibis, I worked for the Yale University School of Medicine where I was the Interim Director of Operations for the Equity Research and Innovations Center and an Associate Research Scientist for the Eastern Caribbean Health Outcomes Research Network Coordinating Center. In these roles, I worked to address health disparities in the United States through research, training, and programming.

9. I have also conducted independent research for other organizations focused on issues related to reproductive health, including the World Health Organization, the Maryland Department of Health and Mental Hygiene, the International Center for Research on Women, the MacArthur Foundation, and Goldman Sachs. This work has focused on examining factors like health care access that contribute to reproductive health disparities.

10. I have published articles in peer-reviewed journals and book chapters in the area of reproductive health care and give presentations at meetings and conferences of social science and medical professionals on a variety of topics related to reproductive health care.

11. I have a doctorate in public health, with a focus on reproductive and women's health, from Johns Hopkins Bloomberg School of Public Health and a Bachelor of Arts degree in psychology from Macalester College.

12. I submit this declaration as an expert in the field of abortion.

My curriculum vitae, which sets forth my experience and credentials in greater detail and contains a full list of my publications, is attached as Exhibit A to this declaration. All of my opinions in this declaration are stated to a reasonable degree of professional certainty.

II. The Impact of Cost on Access to Abortion

A. Financial and Logistical Obstacles to Obtaining an Abortion

13. Nearly half of all pregnancies each year in the United States are considered mistimed or unwanted.¹ Mistimed and unwanted pregnancies, otherwise known as unintended pregnancy, are a public health concern because they are associated with poor maternal and child health outcomes.² Women living in poverty experience higher rates of unintended pregnancy and account for a higher proportion of abortion patients. In 2014, the most recent year for which there is comprehensive national data, 49.4% of women having abortions in the United States had incomes below the federal poverty level (then, \$11,670 for a

¹ Lawrence B. Finer & Mia R. Zolna, “Declines in unintended pregnancy in the United States, 2008–2011,” *New England Journal of Medicine*, 2016, 374(9):843-852

² Adam Sonfield, et al., “The Social and Economic Benefits of Women’s Ability to Determine Whether and When to Have Children,” *New York: Guttmacher Institute*, 2013; Lawrence III, H.C. Testimony before the Institute of Medicine Committee on Preventative Services for Women, *Washington, DC: American Congress of Obstetricians and Gynecologists*, 2011; Pamela Herd, et al., “The implications of unintended pregnancies for mental health in later life,” *American Journal of Public Health*, 2016, 106(3):421–429.

single person, or \$23,850 for a family of four),³ and an additional 25.7% had incomes between 100% and 199% of the federal poverty level.⁴ Most women report multiple reasons for seeking abortion care. However, the most frequently reported include feeling financially unprepared for a child, pregnancy timing, reasons related to their partner, and a desire to focus on their existing family.⁵

14. Research shows that the cost of obtaining an abortion, including the cost and logistics of traveling to obtain an abortion, present significant barriers for women with limited means. For example, in a 2006 sample of 1,209 abortion patients in 11 clinics, among those who said that they would have preferred to have had their abortions earlier, 26% said they were delayed by the time needed to acquire the funds to pay for an abortion, and 7% were delayed because there was no nearby clinic and they had to arrange transportation.⁶ Over 39% of reproductive-age women in the US live in a county that lacks an abortion provider⁷

³ Office of the Assistant Secretary for Planning & Evaluation, U.S. Dep't of Health & Human Servs., 2013 Poverty Guidelines (Dec. 1, 2013), available at <http://aspe.hhs.gov/poverty/14poverty.cfm#thresholds>.

⁴ Calculation based on forthcoming data from the Guttmacher Institute drawn from a nationally representative survey of 8,380 abortion patients in 2014.

⁵ M. Antonia Biggs, Heather Gould & Diana Greene Foster, "Understanding why women seek abortions in the US," *BMC women's health*. 2013 Dec; 13(1):29.

⁶ Lawrence B. Finer, et al., "Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States," 74 *Contraception* 334, 335 (2006).

⁷ Rachel K. Jones & Jenna Jerman, "Abortion incidence and service availability in the United States, 2014," *Perspectives on Sexual and Reproductive Health*. 2017 Mar; 49(1):17-27.

and 92% of women living in rural areas of the country have to travel up to 100 miles to access abortion care.⁸

15. The majority of women seeking an abortion have to cover the costs of care using their own funds.⁹ This unexpected and time-sensitive expense can mean forgoing food, rent, or paying bills in order to afford care.¹⁰ Over half of the women in one study of abortion patients said these costs amounted to more than one-third of their personal monthly income.¹¹ Shifting limited financial resources to cover the cost of an abortion may push women into debt and contribute to financial instability. Financial instability makes it difficult to provide for a child. Women able to save enough for an abortion reported that they and family members who helped pay for the abortion struggled financially for months

⁸Jonathan M. Bearak, Kristein Lagasse Burke, & Rachel K. Jones, “Disparities and change over time in distance women would need to travel to have an abortion in the USA: a spatial analysis,” *The Lancet Public Health*, 2017 Nov 1; 2(11):e493-500.

⁹ Jenna Jerman, Rachel K. Jones, & Tsuyoshi Onda, “Characteristics of US abortion patients in 2014 and changes since 2008,” New York, NY: *Guttmacher Institute*; 2016.

¹⁰ Terri-Ann Thompson & Laura Fix, “All* Above All and Ibis Reproductive Health, Research brief: The impact of out-of-pocket costs on abortion care access,” Cambridge, MA: *Ibis Reproductive Health*, September 2016, available at <https://www.ibisreproductivehealth.org/publications/research-brief-impact-out-pocket-costs-abortion-care-access>; Sarah C.M. Roberts, et al., “Out-of-pocket costs and insurance coverage for abortion in the United States,” *Women’s Health Issues*, 2014 Mar 1;24(2):e211-8.

¹¹ Amanda Dennis, Ruth Manski, & Kelly Blanchard, “Does Medicaid coverage matter? A qualitative multi-state study of abortion affordability for low-income women,” *Journal of Health Care for the Poor and Underserved*, 2014; 25 (4): 1571-85.

after the procedure as a result of having to cut back on groceries and other basic necessities in order to pay back loans, unpaid bills, and credit card debts.¹²

16. In 2008, a group of researchers at the University of California, San Francisco launched a five-year prospective longitudinal study examining health (mental and physical) and socioeconomic consequences of receiving an abortion compared to carrying an unwanted pregnancy to term. The researchers of this “Turnaway Study” recruited 1000 women who sought abortions from 30 abortion clinics across 21 states, collecting both survey and interview data. They found that the most common reason for delay was “travel and procedure costs,” cited by 37% of first-trimester patients and 67% of abortion patients approaching the clinic’s gestational age limit.¹³

B. The Impact of Public Funding Bans on Abortion Access

17. Research has demonstrated that restrictions on Medicaid coverage have detrimental financial and health implications for women and their families. Women struggling to afford an abortion are forced to make immediate financial sacrifices that may adversely affect the health and well-being of themselves and their families, in both the short- and long-term.

¹² *Id.*

¹³ Ushma D. Upadhyay et al., “Denial of Abortion Because of Provider Gestational Age Limits in the United States,” 104 *Am. J. Pub. Health* 1687, 1689, 1691 (2014)

18. Of the “turned away” women who considered trying to get an abortion at another clinic but did not ultimately obtain one, the majority (85.4%) cited “procedure and travel costs” as the barrier to getting care.¹⁴ The researchers observed:

[O]ne of the primary reasons for delay in seeking an abortion was time spent raising the funds to pay for the procedure and travel . . . Public financing and insurance coverage for abortion would have made procedures possible for many of the turnaways, and ability to pay while in the first trimester could have prevented some women from needing later abortions.

A 1984 qualitative study of abortion patients found that Medicaid eligible patients were delayed an average of 2-3 weeks as they searched for funds to pay for the abortion procedure. For some, this delay resulted in a need to obtain second trimester abortion care, a more costly abortion procedure.¹⁵ The burden of finding funds for some is exacerbated if the woman has to travel to receive care, pay multiple visits to the abortion clinic, arrange childcare, or take multiple days off work to receive care.¹⁶

¹⁴ *Id.*

¹⁵ Stanley K. Henshaw, et al., “Restrictions on Medicaid Funding for Abortions: A Literature Review,” *Guttmacher Institute* (July 2009) available at <https://www.guttmacher.org/report/restrictions-medicaid-funding-abortion-literature-review> (last visited Jan. 3, 2019).

¹⁶ “Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States,” *supra* note 10.

19. A Guttmacher Institute study conducted in the state of Missouri following its cutoff of funding for abortion (unless the pregnancy was life-threatening) found that 22% of Medicaid-eligible women who had second-trimester abortions would have had earlier first-trimester abortions if Medicaid coverage had been available and if the women were not delayed by the need to raise money.¹⁷ Moreover, the study found that 58% of Medicaid-eligible women (as compared to 26% of other women) had to, among other things, let bills go unpaid or buy less food and clothing for children in order to pay for their abortions.¹⁸ Research from Ibis Reproductive Health with low income women in seventeen states lends credence to these findings, highlighting that low-income women and their families endure financial hardships to afford care, including forgoing food or schooling, taking out loans, delaying bills or rent, putting large amounts on credit cards, and pawning belongings.¹⁹ The Turnaway Study, which, as noted earlier, found that “[t]he most common reason for delay” among patients who were ultimately turned away from an abortion clinic because they exceeded

¹⁷ Stanley K. Henshaw & Lynn S. Wallisch, “The Medicaid Cutoff and Abortion Services for the Poor,” 16 *Fam. Plan. Persp.* 170, 178 (1984).

¹⁸ *Id.* at 179.

¹⁹ “Does Medicaid coverage matter?: A qualitative multi-state study of abortion affordability for low-income women,” *supra* note 11.

the clinic’s gestational age limit was “having to raise money for travel and procedure costs,” lends further support for this conclusion.²⁰

20. Delaying abortion care has consequences for a woman’s health beyond those that may arise from the sacrifices (e.g., of food) made to secure funding. Although abortion is an extremely safe procedure, the risk of medical complications increases at higher gestations.²¹ States that withhold Medicaid coverage for abortion thus put women’s health at risk by delaying their care.

21. Public assistance helps ensure women can receive safe abortion care in a timely manner. Research indicates that one in four women who would have had Medicaid-funded abortions instead gave birth when this funding was unavailable.²² These findings are consistent with those of Roberts et al., who found—in a study of women entering prenatal care who considered but did not obtain an abortion—that restrictions that create financial and logistical barriers ultimately limit women’s abilities to obtain abortion care²³ and with findings from

²⁰ “Denial of Abortion Because of Provider Gestational Age Limits in the United States,” *supra* note 13, at 1687, 1689.

²¹ Heather Boonstra, “The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States,” *Guttmacher Policy Review* 12, at 15-16 (Winter 2007), available at <https://www.guttmacher.org/gpr/2007/03/heart-matter-public-funding-abortion-poor-women-united-states> (last visited Jan. 3, 2019).

²² “Denial of Abortion Because of Provider Gestational Age Limits in the United States,” *supra* note 13, at 1692.

²³ Sarah C.M. Roberts, et al., “Consideration of and Reasons for Not Obtaining Abortion Among Women Entering Prenatal Care in Southern Louisiana and Baltimore, Maryland,” *Sex*

the Turnaway Study that showed that the majority of women (approximately 70%), who were unable to obtain an abortion from a clinic—85.4% of whom cited travel and procedure costs as a barrier—did not subsequently obtain an abortion elsewhere.²⁴

22. Further evidence of the impact of funding restrictions on women’s reproductive health outcomes comes from a study in North Carolina that examined the effect of short-term cutoffs in state funding for abortion for indigent women. Between 1977 and 1993, the state of North Carolina provided a fixed amount of funds that could be used to pay for abortions for poor women. During five of those years, the fund was depleted, on average, approximately four months before the end of the fiscal year. The authors of the study found that the annual cutoff when these funds were depleted—that is, the period when indigent women had to pay the cost of the procedure without state assistance—was associated with a statistically significant decline in abortions and a statistically significant increase in births. Overall, they found that “approximately 3 in every 10 pregnancies that would have ended in an abortion, had the funds been available, were instead

Res Soc Policy (2018) available at <https://link.springer.com/content/pdf/10.1007%2Fs13178-018-0359-4.pdf>.

²⁴ “Denial of Abortion Because of Provider Gestational Age Limits in the United States,” *supra* note 13, at 1689.

carried to term.”²⁵ As the authors note, it “is rather remarkable that the necessity of paying a couple-of-hundred-dollar fee for an abortion is sufficient to persuade (or compel) some women to incur the much larger financial and personal costs of bearing an unwanted child.”²⁶

23. Another study, based mainly on data collected in Georgia, Ohio, and Michigan, found that 18-23% of Medicaid-eligible women who want an abortion nevertheless carry to term in states where abortion is not covered by Medicaid.²⁷ And according to a study conducted by researchers with the Centers for Disease Control & Prevention, the Texas Department of Human Resources, and others, as many as 35% of Medicaid-eligible women who would have had an abortion had Medicaid coverage been available ultimately carried to term.²⁸

24. Public assistance facilitates timely access to abortion care. A study conducted by Ibis Reproductive Health that collected qualitative data from women in multiple states where abortion is covered in all circumstances through

²⁵ Phillip J. Cook, Allan M. Parnell, Michael J. Moore, Deanna Pagnini, “The Effects of Short-Term Variation in Abortion Funding on Pregnancy Outcomes,” 18 J. Health Econ. 241, 255 (1999).

²⁶ *Id.*

²⁷ James Trussell et al., “The Impact of Restricting Medicaid Financing for Abortion,” 12 Fam. Plan. Persp. 120, 129 (1980).

²⁸ M. Chrissman et al., “Effects of Restricting Federal Funds for Abortion—Texas,” 29 Morbidity & Mortality Wkly. Rep. 253 (1980).

Medicaid found that, with this public financial assistance, women reported that they were able to access abortion services in a timely manner and were able to find abortion clinics that accepted their insurance.²⁹ In a separate study, authors found that pregnant women in states that covered abortion care had lower (~16%) risk of maternal mortality on average, compared to pregnant women residing in states that did not cover abortion through Medicaid.³⁰

25. Because people insured by Medicaid all have low incomes, and because federal policies limiting coverage of abortion care applies only to people covered by Medicaid, these policies target poor families. Restrictions on Medicaid coverage of abortion are also discriminatory against women of color, and in particular Black and Latina women, as they are more likely than White women to be poor and qualify for Medicaid³¹ and are more likely to face financial barriers to abortion care.³² Additionally, because of broader social and economic disparities as

²⁹ “Does Medicaid coverage matter? A qualitative multi-state study of abortion affordability for low-income women,” *supra* note 11, at 1571-85.

³⁰ Marian Jarlenski, et al. “State Medicaid Coverage of Medically Necessary Abortions and Severe Maternal Morbidity and Maternal Mortality,” *Obstetrics & Gynecology* (2017) May; 129(5): 786–794.

³¹ Matt Broaddus & Lighton Ku, “Out of pocket medical expenses for Medicaid beneficiaries are substantial and growing,” *Center on Budget and Policy Priorities*, 2005, available at <http://bit.ly/1iXfb47>; The Henry J Kaiser Health Foundation, “Women’s issue brief: An update on women’s health policy”, 2012 available at <http://bit.ly/1fLFE5R>.

³² “Out-of-pocket costs and insurance coverage for abortion in the United States,” *supra* note 10.

well as existing income, racial, and ethnic inequalities in the US, unintended pregnancy and the need for abortion are disproportionately experienced by poor women and women of color.

26. A review of funding provided from 2010-2014 by the National Network of Abortion Funds to 2,959 US women showed that women were generally unable to raise more than one-quarter of the cost of an average abortion on their own.³³ Although private charitable abortion funds exist in many places in the country to help fill the gap left by a lack of public insurance coverage for the procedure, these funds are unable to cover the full amount of funding needed by most of the people they assist.³⁴

III. Effect of Pennsylvania’s Abortion Coverage Ban on Poor and Low-Income Women

27. Restrictions on abortion can severely impact the well-being of women and their families. Research shows that such restrictions can lead to emotional, financial, and physical harms including poor emotional well-being,

³³ Gretchen E. Ely, et al., “The Undue Burden of Paying for Abortion: An Examination of Abortion Funding Assistance Cases in the United States, Sexual Health,” available at <https://www.guttmacher.org/evidence-you-can-use/medicaid-funding-abortion> (last visited Dec. 19, 2018).

³⁴ Guttmacher Institute, “Medicaid Funding of Abortion,” (Feb. 2018) available at <https://www.guttmacher.org/evidence-you-can-use/medicaid-funding-abortion> (last visited Jan. 3, 2019).

intimate partner violence, and poverty.³⁵ Further, restrictions that impede access to abortion interfere with women’s autonomy, which can have deleterious consequence for women’s life plans and their economic well-being. These findings are consistent with my research with Ibis and strongly suggest that factors enabling women to escape poverty such as higher education, stable housing, employment, and consistent and comprehensive coverage of health care can lead to better health and quality of life outcomes.

28. I understand that, in Pennsylvania, abortions performed up to approximately 13.6 weeks of pregnancy, as measured from a woman’s last menstrual period (“LMP”), cost \$435-\$580; abortions performed at 14.0-16.6 LMP cost \$815-\$855; and abortions performed from 17-18 weeks LMP cost \$915-\$955.³⁶ Given that forty-two percent of women seeking an abortion have

³⁵ M. Antonia, Biggs, et al., “Does abortion reduce self-esteem and life satisfaction? Quality of Life Research,” 2014; 23(9):2505-2513; Corinne H. Rocca, et al., “Women’s emotions one week after receiving or being denied an abortion in the United States,” *Perspectives on Reproductive Health*, 2013; 45(3):122-31; Melissa S. Kearney & Phillip B. Levine, “Why is the teen birth rate in the United States so high and why does it matter?” *The Journal of Economic Perspectives*, 2012; 26(2): 141-166; Sarah C. M. Roberts, et al., “Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion,” *BMC Medicine*, 2014; 12: 144; Laura F. Harris, et al., “Perceived stress and emotional social support among women who are denied or receive abortions in the United States: a prospective cohort study,” *BMC Women’s Health*, 2014; 14: 76; Diana Greene Foster, et al., “Socioeconomic outcomes of women who receive and women who are denied wanted abortions,” *American Journal of Public Health* (2018) Mar; 108(3):407-413.

³⁶ Planned Parenthood of Pennsylvania, Fees for Services, available at <https://www.plannedparenthood.org/planned-parenthood-western-pennsylvania/patients/fees-services> (last visited December 13, 2018).

household incomes below the federal poverty level in the United States, these costs present a significant barrier to access to safe abortion care.³⁷

29. In order to afford an abortion, a poor or low-income woman in Pennsylvania will be required to make severe financial sacrifices, placing her family and herself in an economically vulnerable situation. Out of pocket health expenses that are significantly large in proportion to a household's ability to pay can be considered "catastrophic."³⁸ Such expenses cause severe financial hardship, causing women to either not obtain a wanted abortion at all, or attempt to meet the cost of an abortion in ways that have harmful consequences in other aspects of their lives: not paying rent or utilities; skipping car payments; reducing food intake; and borrowing money using costly "payday" loans at high interest.

30. Data from the Guttmacher Institute shows that in 2014, approximately "85% of Pennsylvania counties had no abortion clinics and 48% of Pennsylvanians resided in these counties."³⁹ This represents a large proportion of Pennsylvania women who will have to travel outside of their county to seek

³⁷ Rachel K. Jones, Lawrence B. Finer, Susheela Singh, "Characteristics of U.S. Abortion Patients, 2008," The Guttmacher Institute, available at <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2008> (last visited Jan. 3, 2019).

³⁸ Adam Wagstaff, et al., "Progress on catastrophic health spending in 133 countries: a retrospective observational study," *Artic Lancet Glob Heal.* 2018; 6:169-179.

³⁹ "Abortion incidence and service availability in the United States," *supra* note 7.

abortion care. Transportation and travel related costs such as lost wages, hotel stays, and child care, increase the cost of a clinic based abortion.

31. Because raising money takes time, many of these women will be delayed in accessing abortion care. Others will find themselves unable to raise the money they need before their time to get an abortion runs out. They will have no option but to continue with the pregnancy. In some cases, they may be unable to adequately support themselves, their newborn child, and other children they already have and, in most cases, will be far less likely to escape from poverty.

32. Pennsylvania Medical Assistance coverage for abortion would significantly alleviate the financial burden on poor and low-income women seeking abortion care, making it far less likely that these women will be delayed in or prevented from accessing care. Coverage will also mitigate the painful and dangerous sacrifices required to obtain this needed care and remove a major obstacle in the path of a woman attempting to avoid or overcome poverty.

33. Based on this information about Pennsylvania, my expertise in the relevant research literature, and my own research into these matters, I have no reason to believe that the decades of research consistently finding that the denial of Medicaid coverage for abortion impedes women's ability to access abortion do not hold true in Pennsylvania today.

I make this declaration subject to the penalties of 18 Pa. C. S. § 4904 (unsworn falsification to authorities).

Dated this 11 of January, 2019.

A handwritten signature in cursive script, appearing to read "Terri-Ann Thompson", is written above a horizontal line.

Terri-Ann Thompson, PhD.